TESTIMONY of

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before the

HOUSE COMMERCE SUBCOMMITTEE

ON HEALTH & THE ENVIRONMENT

June 27, 2000

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting us to discuss our progress in streamlining Medicare policies and helping providers participate in the Medicare program.

We all share the goals of minimizing Medicare regulations and maintaining and strengthening the program=s efficiency and integrity. I think we also all appreciate the challenges these sometimes conflicting goals can present. The laws governing Medicare are complex and extensive, and its administration is complicated -- in large part because medicine and our ever-evolving health care delivery system are complex. And Medicare, according to the General Accounting Office, is intrinsically at high risk of fraud, waste, and abuse because of its size and scope.

Provider concerns about these issues have been heightened by the Balanced Budget Act=s (BBA) substantial impact on providers, and by our unprecedented success in fighting fraud, waste, and abuse, which has cut the Medicare payment error rate nearly in half. We greatly appreciate the opportunity this hearing provides to explore additional actions we might take to help providers participating in the program.

We are already taking a number of steps to review our policies and procedures for potential areas in which they might be streamlined or simplified. Last year, for example, we worked with Congress to develop the Balanced Budget Refinement Act (BBRA). We also took a number of administrative steps to help providers adjust to changes mandated in the BBA. And, as the President has announced, we want to enact further refinements to ensure that providers receive adequate payment and beneficiaries continue to have access to quality care.

We have several other initiatives underway to help providers and better target our program integrity efforts.

- We have launched a wide-ranging education initiative to help providers understand Medicare policies and how to bill correctly, and to prepare them for the new payment systems mandated by the law.
- We have formed a Physicians Regulatory Issues Team to review, clarify, and simplify rules, and ensure that clinician concerns are heard as we develop policies and guidance.
- We have worked with the HHS Inspector General to develop compliance guidance for providers, including those issued just this month for physicians, and are inviting public comments on this

guidance.

- We are studying payment error rates at the contractor level so we can focus education and error prevention efforts more sharply.
- We are requiring all claims processing contractors to establish toll-free lines for providers to call with billing questions.
- We will be testing simplified evaluation and management guidelines designed to reduce the documentation required for physicians to justify their claims.
- This month we sent a letter to more than 800,000 providers on how to address the most common documentation problems.
- And we are conducting an increasing number of town meetings and other endeavors to communicate directly with providers about their concerns.

BACKGROUND

The Health Care Financing Administration (HCFA) is the largest health insurer in the nation, covering some 74 million Americans through Medicare, Medicaid, and the State Children=s Health Insurance Program. It will pay about $368 billion for health care services this year. For Medicare alone, we pay out more than $210 billion each year for nearly one billion claims by some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers. The people who work at HCFA care deeply about serving the 39 million senior citizens and people with disabilities who rely on Medicare, and I am proud of our record of accomplishments.

The innovations we have developed in quality improvement and prospective payment systems that promote efficiency have been widely adopted by other public and private sector insurers. We also have important statutory responsibilities to ensure that quality and safety standards are met for all patients served by health care providers, as well as to support medical education.

The volume of Medicare laws and regulations covering all these responsibilities, while often greatly exaggerated, is substantial. The Social Security Act includes 900 pages of legislative language related to all HCFA programs. For all these programs including Medicare, we have issued 1,700 pages of regulations to implement this legislation. Individual providers need to understand only the fraction of these pages that relate to the specific services they provide.

Our process for developing and implementing regulations is fair and open. Providers and other members of the public have ample opportunity to comment and seek adjustments. They have extensive, rule-based information on what is and is not allowed, rather than arbitrary decisions. They have due process rights. And we are held accountable to providers and other members of the public through the Executive, Congressional, and Judicial branches of government. This, as providers know, is far different from the way private insurers conduct their business.

Virtually everything we do in regulations is in response to legislative mandates or directives. Congress is frequently very prescriptive in telling us how to implement the legislative changes it makes to our programs. This was particularly true with many of the 335 BBA provisions related to our programs, including new prospective payment systems that require substantial change for skilled nursing facilities, home health agencies, and hospital outpatient departments.

The BBA represented the agreement of Congress and the Administration to slow the growth in Medicare

spending. Reducing spending by such an unprecedented amount in a relatively short time was an unequaled challenge. Virtually every hospital, physician, home health agency, skilled nursing facility, durable medical equipment supplier, and other health care provider in the country has been affected, and almost all have seen an impact on their revenues.

Such significant change with such an ambitious implementation schedule has created pressures and dissatisfaction. HCFA, of course, was the face of the BBA for providers. While the past two years have not been easy, I do believe we have done a good job, albeit not a perfect job, in implementing the law and remaining true to the law's intent, given the time frames, the competing interests of program stakeholders, and the complexity of the changes.

The BBA and the Health Insurance Portability and Accountability Act of 1996 both also included important new tools to help us prevent improper payments. The vast majority of providers are honest and we have no intention of punishing them for honest errors. However, we have an indisputable obligation to try to pay fairly, prevent and identify errors, recoup improper payments, and root out the small number of providers who are not honest. This is a leading concern among beneficiaries, who tell us that they feel that fraud, waste, and abuse are rampant in the system. Still, moving in just a few short years from relatively lax program integrity efforts to a zero tolerance policy has been challenging for both us and providers.

But while difficult, the BBA and our successes in protecting program integrity have both been essential for preserving and strengthening the Medicare program. The Part A Hospital Insurance Trust Fund, which was projected to become insolvent in 1999 when President Clinton took office, is instead now projected to remain solvent until 2025.

Improving Guidance and Education

The need to continue with payment reforms, spending growth controls, and program integrity initiatives underscores the importance of our increased provider education efforts. We are therefore redoubling our efforts to reach out to all providers to ensure that our guidance on Medicare policies is clear, understandable, and consistent among the private insurance companies that, by law, we must contract with to process claims. We have initiated a wide range of provider educational activities.

For example, we are:

- airing satellite broadcasts to hundreds of sites across the country on topics of interest to providers such as Medicare coverage and payment requirements, new Medicare benefits, women=s health and adult immunization initiatives, and more;
- surveying health care providers nationwide and analyzing data collected to develop new education strategies for reaching out to Medicare providers;
- developing computer-based training modules for providers on topics such as proper claims submission, Medicare Secondary Payer rules, and Medicare fraud and abuse efforts;
- writing articles on timely topics for fiscal intermediary bulletins and other publications targeted toward physicians and other providers;
- maintaining the *www.hcfa.gov/medlearn* web site to provide up-to-date, easily accessible material on a wide variety of issues, including interactive courses on the proper filing and documentation of

claims;

- communicating on a regular basis through conference calls with national and state provider associations and issuing nationwide mailings on issues of interest;
- sharing feedback with providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims so we can reduce the number of improper claims among the vast majority of providers who make only honest errors; and
- working to ensure that contractor toll-free service lines are responsive to provider questions.

We also are strengthening and standardizing the way in which our contractors carry out provider education and customer service activities. We require all contractors to provide information via printed bulletins and newsletters, as well as via the Internet. Each contractor is required to link to our website from their website in order to give providers access to our Medicare learning network. We established a component within HCFA to specialize in education and training for the provider community. And we recently notified contractors that they may no longer charge providers a fee for attending training on Medicare issues.

Among the most important of our efforts to improve provider guidance and education is the development and testing of simplified evaluation and management guidelines that are designed to reduce the documentation required for physicians to justify their claims. When our Administrator, Nancy-Ann DeParle, arrived at the agency and learned of physician dissatisfaction with a new revision of the guidelines, she ordered that physicians be allowed to use either the new or old version, and instructed our staff to review the situation.

As a result, HCFA physicians started over with three goals in mind:

- simplify the guidelines;
- reduce the burden; and
- foster consistent and fair medical review.

We have developed simpler versions of the guidelines that we believe provide clear, unambiguous guidance and streamline the documentation required for clinically appropriate record keeping and verification that services were medically necessary and rendered as billed. We are going to rigorously test these new versions in the real world of clinical practice. We will also test training mechanisms to determine the best way to help physicians learn how to use the new guidelines.

Throughout the process we will seek physician input on whether the new version revisions being tested are, in fact, better for them in the real world of day-to-day clinical practice. To begin the feedback process, we held a public meeting last week in Baltimore to lay out our proposed guidelines and discuss our testing plans with leaders of physician organizations.

Another good example of our increased education efforts is our current undertaking in preparation for implementation of the hospital outpatient prospective payment system, which was mandated by the BBA. This initiative, involving hospitals across the country, is unprecedented in its scope and second in size only to our Year 2000 provider outreach efforts.

As part of this effort, we are:

- holding nationwide train-the-trainer sessions for claims processing contractors who, in turn, are providing training for local hospitals and billing vendors in their areas;
- conducting additional training sessions for representatives from national and state hospital associations, as well as software vendors, in the coming months;
- posting training materials for providers on our *www.hcfa.gov* website;
- sponsoring a national satellite conference specifically on the hospital outpatient PPS;
- instructing all contractors to take immediate steps to disseminate final program information as soon as we release it, and to post these instructions on their websites; and
- encouraging contractors to publish articles in their provider bulletins and conduct outreach to get detailed information to providers.

Responding to Provider Concerns

Parallel to our educational initiatives, we are working to improve the service we provide to physicians and ensure that our regulations help, rather than hinder, the provision of high quality patient care. To do so, we have doubled the number of physicians at HCFA and put them in key positions. We have rejuvenated and sharpened the focus of our Practicing Physicians Advisory Committee to ask their advice on how our policies affect real-life clinical practice.

We also have established a new, internal, physician-led Physicians Regulatory Issues Team. This team is developing new systems to create rules and regulations that are simplified, clarified, and refined specifically to reduce administrative workloads on providers and better meet beneficiary needs.

To do this, the Physicians Regulatory Issues Team is:

- developing an Aimpact analysis@ initiative to ensure that we explicitly address the impact on practicing physicians before and after issuing new policies or interpretations of existing policies, and has already begun piloting these ideas with some current regulations;
- developing a Asentinel practices@ system to query and monitor a selection of diverse types of physician offices across the country in order to receive ongoing feedback on the real-world, day-to-day impact of Medicare rules;
- developing a Aphysician service core group@ in which staff involved in physician-related efforts -- from developing regulations to outreach and education -- will work together to ensure clear, concise, and consistent communication;
- enhancing communication at the State and County level by having our regional offices develop outreach that reflects the needs and character of local physician communities;
- developing a set of Afrequently asked questions@ for physicians, as well as a Arules of the road@ brochure on the basics of Medicare participation for physicians;
- hosting monthly conference calls with physician organizations across the country to address real-time and emerging issues, such as hospital coding, Peer Review Organization efforts, Medicare payment error estimate, and new preventive health benefits; and
- upgrading our website to provide clearer, more user-friendly information for physicians.

Other Administrative Action

We also are taking a number of additional administrative actions to moderate the impact of the Balanced

Budget Act, reduce administrative workloads, and assist providers in meeting the needs of the patients they serve. For example:

- We are revamping the advanced beneficiary notices that providers give to beneficiaries when providing a service or item that may not be covered by Medicare. The goal is to provide a plain-language, user-friendly document explaining that a given service or item may not be covered by Medicare and that the beneficiary may be responsible for payment, so the beneficiary can make an informed consumer decision. A new draft notice for physician and other Part B services has recently been reviewed by our Practicing Physicians Advisory Council, and will soon go into the Paperwork Reduction Act clearance process, which includes opportunities for public comments. A new draft advanced beneficiary notice for home health services is already in the Paperwork Reduction Act clearance process.
- We are delaying implementation of the hospital outpatient prospective payment system until August 1. We are distressed about having to postpone the benefits of this new system for beneficiaries, but the one-month delay will give both us and hospitals needed time to be fully prepared for this substantial change. We also are asking hospitals to not collect deductibles or coinsurance from Medicare beneficiaries beginning August 1 until we notify them of the correct amount. And we will provide all hospitals with a Aplain language@ flyer to help explain the change to beneficiaries.
- We are expanding the number of medical devices for which Apass-through@ payments will be made under the new outpatient prospective payment system and continuing to work with the device industry to determine additional devices for which these payments can be made under the law. We also have committed to making unprecedented quarterly updates to the pass-through list to ensure that the outpatient prospective payment system does not inhibit development and use of new technologies.
- We are postponing expansion of the BBA=s Atransfer policy@ for all hospitals for a period of two years, through 2002. As a result, the transfer payment limits will apply only to the current 10 Diagnosis Related Group (DRG) categories, as prescribed by the BBA. We are carefully considering whether further postponement of this policy is warranted.
- We are implementing new policies to make it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. As a consequence of these policy changes, rural hospitals will receive higher reimbursement. Similarly, we are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining outpatient payment rates that is used to calculate inpatient rates.
- We are helping home health agencies by extending the time frame for repaying interim payment system overpayments from one year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds. And we have eliminated the sequential billing requirement.
- We are helping skilled nursing facilities by refining the payment classification system in a budget neutral way to increase pay for medically complex patients.

Assisting Medicare+Choice Plans

We also have taken important steps to help managed care and other health plans participate in the

Medicare+Choice program. Final Medicare+Choice regulations announced last week incorporate many industry recommendations. They include several provisions that reduce administrative requirements for plans while maintaining strong beneficiary protections.

For example, they:

- permit flexibility to tailor benefits under M+C plans through the use of full-county segmented service areas with differing benefits;
- reduce quality assurance requirements for Preferred Provider Organizations, as defined by the statute;
- implement deeming procedures and expansion of deemable categories to include not only quality assurance and confidentiality requirements but also access standards, advance directive requirements, and provider participation and anti-discrimination requirements; and
- reduce the re-entry limitation for M+C organizations that terminated participation from 5 years to 2 years.

We also earlier announced plans to modify our current risk adjusted payment system to pay more for the higher costs of providing high quality care for patients with congestive heart failure. We are developing a revised phase-in schedule for risk adjustment in conjunction with the Medicare Payment Advisory Commission, health plans, and beneficiary groups. And, of course, our proposed prescription drug benefit would result in more than $50 billion over 10 years in additional payments to Medicare+Choice plans.

We realize that health plans choose to participate in Medicare+Choice based on business decisions, but these changes and other initiatives we=ve announced underscore our willingness to be responsive to constructive industry suggestions by granting flexibility when possible.

Ensuring Program Integrity

Although we recognize the need to reduce the administrative workload on providers and simplify documentation requirements where we are able, we also have a responsibility to be prudent stewards of the trust funds and maintain the financial integrity of our programs. We recognize this is a delicate, but critical, balance.

Today, our efforts to identify fraud, waste, and abuse in all of our programs are more effective than ever before. From April through September, 1998, we stopped about $5.3 billion from being paid to providers for inappropriate claims. Our anti-fraud efforts returned nearly $500 million to the federal government, a 65 percent increase over the previous year. We have reduced the Medicare error rate by almost half since 1996, and maintained that progress in 1999. And total Medicare integrity program savings in fiscal year 1999 totaled $9.9 billion.

Yet Medicare pays 95 percent of Aclean@ claims submitted by physicians without asking for any medical record to confirm the accuracy of the code, the adequacy of the documentation, or the appropriateness of the service.

We realize that our efforts to reduce fraud, waste, and abuse have generated concern among some providers. As we have said time and time again, we know the vast majority of providers are honest and conscientious, and we have no intention of punishing anyone for honest mistakes. If providers do make

billing errors, we want to find those errors, preferably before we make payment. But there is a world of difference between honest errors and the kind of outright fraud we have been so successful in fighting.

While some physicians have said they are afraid of being jailed for minor errors, we do not refer providers to law enforcement for minor or occasional errors. Only the most serious matters are referred for prosecution.

We have spoken with hundreds of physicians about these concerns, and repeatedly asked them to tell us if they know of any instances of improper pursuit of physicians for honest, inadvertent errors. In fact, while some 660,000 physicians receive Medicare payments each year, in the past two years, physicians accounted for only 52 of some 500 criminal health care convictions, at a time when the Department of Justice has achieved an 85 percent conviction rate on cases it takes to court.

CONCLUSION

We are committed to helping providers participate in Medicare and to minimizing the amount of regulation, paperwork, and oversight as much as our obligation to taxpayers and beneficiaries will allow. We are taking many steps to be more responsive to provider concerns, and are open to considering others that may be appropriate. The past few years have been particularly difficult for providers due to the many BBA changes and our robust program integrity efforts.

But now, I believe, we are turning a corner. We are moving beyond BBA implementation. We are strengthening and expanding efforts to help honest providers. And we are more sharply targeting the kinds of fraud, waste, and abuse that we have had so much success in fighting. I thank you again for holding this hearing and giving us yet another opportunity to address these issues. And I am happy to answer your questions.

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